

Indiana State Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005089 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED 05/04/2016 |
| NAME OF PROVIDER OR SUPPLIER ST MARY'S MEDICAL CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 3700 WASHINGTON AVE EVANSVILLE, IN 47750 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| S 000 | <p>INITIAL COMMENTS</p> <p>This visit was for one State hospital complaint investigation.</p> <p>Complaint number: IN001183470 Unsubstantiated: lack of sufficient evidence.</p> <p>Survey date: May 4, 2016</p> <p>Facility number: 005089</p> <p>St. Mary's Medical Center is in compliance with 410 IAC 15-1.5-6, Nursing services, Indiana Hospital Licensure Rules.</p> <p>QA: cjl 06/03/16</p> | S 000 | | |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE